Special Article

Is Private Practice Dead?

JOHN S. MILLIS, PH.D., *Cleveland*

THE TOPIC OF my remarks was not necessarily of my choosing. It was assigned to me. I shall not take it literally. The topic in the program is "Is the Private Practice of Medicine Dead?" There are two words in that question which are particularly important. First is the word *private*. It is one of those words that I think we have corrupted and tried to use to express things which it does not mean. The word *private*, from the Latin *privatus*, simply means that it is set apart from the state. It is one of those negative words, for its meaning is not positive, but rather that it is not something else. The best synonym I know for it is voluntary —that is, in contrast to that which is required by law or by dictatorship. It is that which we do from within us. Private is not the antonym of public, for many things are both private and public at the same time. The private practice of medicine is in the public interest and for the public good.

The second word of particular importance in the title is *death*, which is somewhat more difficult to define. I have read a few articles and listened to quite a few discussions about this word recently. One of my good friends in Cleveland, Dr. Claude Beck, maintains that death is not an event but rather a process. I would prefer to use this word in the context that a system or a family or a genus does not die; rather it becomes extinct. Therefore I will modify the title this way: "Will the American Voluntary System of Medical Care Become Extinct?" I have replaced there, you see, the word *private* with the word *voluntary* and the word *dead* with *become extinct.*

My choice of a definition for the word *dead* suggests immediately to you, I am sure, as it did to me, that one might approach this subject through the analogy, with a consideration of the process of evolution. The basic fact of evolution, as we have all learned, is that those genera with the capacity to adapt to changes in the environment survive. Those without the adaptive capacity die as individuals and become extinct as a genus. Thus, the dinosaur could not adapt but *homo sapiens* could adapt. Perhaps we can approach this question, "Is the voluntary system of medical care about to become extinct?" by analyzing the changing environment and estimating the capacity of the system to adapt to these changes in the environment. I shall not discuss all the factors in the environment which one might think of, but rather choose only six. They are as follows: first, the public's concept of health care; second, the rising expectations of the universal availability of health care; third, the effects of specialization; fourth, the effects of growing institutionalization; fifth, economics; and sixth, and most important in my judgment, the potential of the voluntary way.

The Public Concept of Health Care

Thinking about these factors now one at a time —first, the public concept of health care. It wasn't too long ago that we defined the necessities of life as food, clothing and shelter. Education and health care were not exactly luxuries, but they were things that people, many people, did without because they did not deem them to be as necessary as food, clothing and shelter. But today, our list of necessities has to be amended and I am sure that we would all agree that it would run: food, housing (including sanitation), clothing, education and health care. This is to say, in other words, that health care has shifted from a concept of a privilege to a concept of a right—that is, a necessity. A right is always recognized legally and a right is promised by public policy and by enacted law. It is immediately evident, I think, to all of us that

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The author is Chancellor of Case Western Reserve University.

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Reprint requests to: John S. Millis, Ph.D., Case Western Reserve University, Cleveland, Ohio 44106.

this abrupt change from the role of a privilege to the role of a necessity and a right affects the relationship between supply and demand. Demand escalates by quantum leaps whereas supply must grow only gradually. We therefore have shortages, and shortages always demand accommodations and very difficult choices.

The second change in the environment I would direct your attention to is the rising expectations of our people as to the universal availability of medical care. That this is a changing area and a force of change is a very natural consequence of the change in the concept from that of a privilege to that of a right. But availability is thought of, I think, in four ways. Health care should be available without regard to race, sex, age. Second, it should be available without regard to economic circumstances of those who need it. Third, it should be available without regard to geographical considerations. Fourth, it should be universally available without an adverse effect on the standards of quality. I think we have always accepted the first two of these conditions, namely, the social and economic ones, and certainly medicine's record is a very proud one indeed, for the physician has always cared for the needy. He has given of his time and his energy and of his knowledge without expectations of compensation. I would point out to you that no other profession that I know of, not even the ministry nor teaching, has ever quite acted this way. But we have never considered, I think, the last two conditions as being physically possible. Medical care facilities have always been located to serve the best interests of the greatest number. Inevitably, therefore, they have been more available to some than to others. But we have rationalized this by saying that it was a matter of choice to the individual if he elected to live 50 miles from the nearest physician or 200 miles from the nearest hospital. If he wanted to live in the boondocks, this was his right and his privilege. Our planning of medical care, I think, has usually striven for a balance between quantity and quality, but always recognizing and insisting that there be a minimum of quality and recognizing that, above this minimum, large increments in quality of care must inevitably result in a decrease of the quantity which was available.

Specialization as a Force of Change

The third force of change in the environment which I think is affecting the system of the delivery of medical care is specialization. Specialization is, of course, inevitable. The increase in knowledge in any field demands a limitation in the area of mastery and, therefore, differentiation among its practitioners. This differentiation must accelerate with time, since knowledge continues to grow, and the greater the knowledge, the smaller the segment one person can possibly manage. The mark of the specialist, as I view him, is that he can perform at a high level of skill in an ever more limited field. Thus medical care, automatically through the force of specialization, becomes of a higher and higher quality and we shall see the same increment in quality in the next two decades that we have seen the last two decades. It is of a higher quality because the skill is more complex and is much more sophisticated. In general, the more sophisticated the skill, the more time is required for its performance and hence there is a decrease in productivity and there is less quantity of service per doctor available. Think only of the time, energy and manpower required for open heart surgery as contrasted to removal of an appendix. A secondary factor is that the organization of the system is such that a specialist works much of his time at a level below his greatest competence, and this is an additional loss of efficiency and of productivity.

My fourth point of change in the environment is the effects of growing institutionalization. There is a generic and inevitable four-step, logical sequence that applies to medicine, industry, education or government equally. First, an increase in knowledge requires differentiation and specialization. Second, specialization results in a division of labor. Third, when there is a division of labor, then organization must inevitably ensue. And fourth, organization demands an institutional framework and therefore the practice of the art or the skill becomes institutionalized. The evidence of this process in medicine is clear. Look at the rise in the importance of the hospital as the center in which we deliver so much of that care. Think about the rise of group practice, another form of institutionalization. Think about the rise of the great clinics, such as the Mayo and the Cleveland clinics, and about the rise, in your own state, of health plans such as the Kaiser Permanente. My point is this, that since knowledge will continue to increase, institutionalization must also increase and the problem in adjusting a one-to-one service of physician to patient in the conditions of an institution is difficult.

The Economics of Quality

The fifth point of change in the environment that I would point to is that of economics. My ideas are relatively simple here. It is obvious to me that productivity is declining with each increment in the quality of care. Second, the efficiency and use of human resources is also declining, or at least it is not increasing. When productivity and efficiency fall, price must rise. It is an inevitable law of economics. But this is not to say, of course, that the higher price did not buy a higher quality. It does say, however, that in a system for the delivery of medical care we have not found the way to get higher quality through increased productivity and higher efficiency. If one would contrast the delivery of medical care to the delivery of, for instance, telephone communications, one would have to say that the Bell System had done much better than the profession of medicine has.

Last, I would ask you to think about the potential of the voluntary way. When I went to school there was a basic assumption concerning the role of government that was very simple. It was government's responsibility to do those things for the citizens which the citizens could not do for themselves. This assumes that much of society's business will be carried out in a voluntary system. But society's problems have become more complex. As we become more urbanized and more industrialized, as the number of people becomes greater, the mechanism to deal with their needs must have greater capacity and higher skills. This is true both in the governmental sector and in voluntary enterprise. Government has recognized this and has tried to organize and to staff itself to cope with increasing complexity and difficulty. In contrast and for the most part, in the voluntary sector, with the exception of industrial corporations, we have tried to make do with the older and unmodified mechanisms. We run universities and hospitals with mechanisms which were developed in the middle of the 19th or even in the 18th century, and wonder why they will not cope with the problems of the last third of the 20th century. This has given rise in the minds of many of our people to the assumption that the voluntary way just simply cannot manage large affairs and be effective in the public interest. But the truth of the matter is that we have never taken the time to look at the voluntary way and decide how, if at all, it can be strengthened and rendered more competent.

Adaptability of the Voluntary System

I come now to the second part of my remarks and some estimates of the capacity of our voluntary system of medical care to adapt to the six factors of change in environment which I have just covered. First, the public concept of health care. Medicine cannot disagree with the concept of the necessity for and, therefore, of the right of people to health care. It has always behaved this way and has done its very best to give care to all. The real problem here is coping with a conflict. A right is legally enforceable and it is enforceable against something or somebody. In our historic concept of medicine, the relationship is directly between patient and physician; and logically, therefore, the right could be enforceable against the physician himself. But this negates the freedom of the physician to accept or reject a patient, which also seems to be a part of the voluntary way. We shall have to look at the possibility of admitting as a matter of public policy that the institutions of medical care are so centrally involved that the right is enforceable against them rather than against the physician as an individual. My judgment here is that organized medicine must examine this question rapidly and probably recognize that the role of the institutions for delivery of care really must be altered to make it capable of response.

My second point of the change in the environment is the expectation as to the universal availability of medical care. We have already accepted this, as I remarked a moment ago, concerning age, sex, color, religion or economic status. But the real problem is to have universal availability without regard to geography and without a decrease in quality. We can mitigate the effects of geography by various programs of collaboration, such as the heart-stroke-cancer legislation. But more importantly, there must be a voluntary end to parochialism and isolation among medical institutions and medical people. We simply have to face up to the fact that not every hospital can be all things, to all patients. We certainly need to do some regional planning and we had better get at it and forget about politics. The problem of quantity versus quality is more difficult. The solution may lie in finding brand new ways to deliver medical care, and I shall speak about that in greater detail in a few minutes.

The third force of change was the effects of specialization. As I mentioned, this is an irreversible trend and where we now see specialization,

next we shall see sub-specialization and 15 years from now there will be sub-sub-specialties. In my judgment a new way to deliver medical care is required. I think there is a growing minimum in the size of the basic organization which will be able to render medical care. We must have a large quantity and high quality simultaneously. We do need a mechanism to produce a greater rationality in the selection of the field of specialization so that we have a more equitable distribution of manpower throughout all fields. We need new forms of differentiation of the physician, new specialties, if you will, such as the primary physician, the creation of which I have been advocating for several years. I would point out to you that these adaptations may prove to be the easiest ones to carry out for they are wholly within the control of organized medicine and you do not have to force government or other parts of our society to agree with you on this.

The fourth point was the growing institutionalization in the delivery of medical care. That's here to stay. It also will grow. The hospital will become more and more central and other kinds of institutions will become more and more the focus for the delivery of medical care. But the only real problem is: How can the physician be involved in the institution and still be free? There is a way. I urge you to look at the university and see if there is an analogy and a parallel there which you can use. In the university we have managed with, I think, good success to serve the necessities of specialization and the division of labor. That is institutionalization, but we have preserved a large degree of freedom for the professional known as teacher. It is done by a process of governance involving large grants of power and responsibility to individuals whom we call officers of instruction or faculty, and by giving other powers to groups of peers which, of course, is the organized faculty.

Research Into Ways to Deliver Health Care

With reference to the question of economics, it seems to me apparent that we cannot cope with the cost problem in the present system of medical care for very long. What, in my judgment, is required, is a second front in medical research. My idea of the second front is research in the delivery of medical care—research with the same kind of attack we have mounted in the bio-medical sciences and which has been so productive and so effective. We must find out how we can use the knowledge in many other fields, such as, engineering, management, systems engineering, computers, and others. There must be a way to be better and also be more efficient. The findings of the research of the second front, as I call it, will probably be very disruptive of the *status quo* and there will be very many members of the medical profession who won't like it. None of us does like change. But I must remind you that those changes, if voluntarily made, will be far less disruptive than going to a governmental service for the delivery of medical care.

Last, what about the potential non-viability of the voluntary way? This is perhaps the most important point I have to make to you. It precedes all the other adaptations about which I have been speaking and it is fundamental to everything else. The adaptation which we must be able to make voluntarily requires, first, that we realize that change is not a discontinuous phenomenon but a continuous phenomenon. This we learned in evolution, every one of us, years ago. Whenever there is a continuous and continuing evolutionary change, there must be continuing and continuous adaptations. The mechanism which we need, therefore, within organized medicine, is a mechanism designed for evolution, not for revolution and not for the *status quo,* but for one single thing—adaptation. A mechanism to produce and to lead change, and not to oppose it. What I have said is directed to the individuals here. You are the ones that must make the voluntary system work. You are the ones that have committed time and energy and intellectual power to the problems of organized medicine and assumed its responsibilities. You are the ones that must find the way to strengthen your mechanisms so that they are adequate to the task of adaptation of which I have been talking. Though I have used the analogy of evolution, there is one very great difference to which I must call your attention. The adaptive capabilities of the dinosaur were determined in his genes and in his chromosomes. But the adaptive capabilities of organized medicine are determined by intelligence and human will.

How to Succeed with Success

May I close by saying this: I am an eternal optimist and I am an eternal optimist about the medical profession. I do not believe that the voluntary health system of America is about to become extinct. The basis of my belief is that as I look

at medicine and see its problems and listen to you discuss them, wrestle with them, and seek solutions, I am constantly reminded that your problems are problems of success and not problems of failure. If you had not rendered a service which the people of this country had found absolutely essential and necessary, no one would think about it as a right and there would be no demand for universal availability. This is not to say that the problems are any less severe, less complex, less baffling. It does say something about the spirit with which people like you can adjust themselves to those problems. The same intellectual capacity, the same involvement and dedication, the same creativeness and inventiveness which have brought medicine its huge success and the problems of success, I believe are capable of solving those problems.

STAYING HOME NOT A CURE FOR "SCHOOL PHOBIA"

"Once it's established that a child has a school phobia, the best treatment by far is to get him back in school immediately. The longer the syndrome goes on, the harder it is to treat. While the child is not in school, he does not feel psychiatrically disturbed—that is, whatever conflict he has is resolved by his not going to school. So he's happy as a clam sitting home, and his mother often is a little bit happy as a clam, too, and will act very solicitous toward him. This situation can be terminated by either the parent or the child. The kid can make such a pain in the neck of himself at home if he doesn't want to be there that the mother is forced to send him back to school; or the mother can boot him out of the house and get him back to school.

"The physician can also play a role—particularly early when it's much easier to solve—by absolutely insisting that the child go back to school. In the chronic cases we see, there are often a hundred objections raised: 'If I go back to school, I'll have a stomachache.' 'Well,' I say, 'your stomach aches at home, why couldn't it ache in school?' 'Well, I'll vomit,' he tells me. I say, 'Fine. Take some brown paper bags and vomit in those.' The trick is somehow to create a feeling of inevitability so that whatever happens the child must go to school. Often the school's support must be solicited—that is, the principal, or somebody in the school, must agree to keep the child even if he begins complaining.

"When the child is confronted with a really solid wall, he will very quickly go to school, and there'll be no trouble. This doesn't mean that [going to school] will solve his basic problem, for which the family may need counseling; but I think it's very important to realize that the basic problem is not likely to be solved while the child is at home."

—JEROME L. SCHULMAN, M.D., Chicago

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